# COMMUNITY CARE CLIFTON PARK PEDIATRICS

## Patient Information

Name:_____ D.O.B.: _____ Date: _____

Address: _____

Cell Phone: _____ Work Phone: _____ Home Phone: _____

## Parent & Sibling Information

Mothers Name: _____ D.O.B.: _____

Address: _____

Cell Phone: _____ Work Phone: _____ Home Phone: _____

Fathers Name: _____ D.O.B.: _____

Address: _____

Cell Phone: _____ Work Phone: _____ Home Phone: _____

Siblings:

Name: _____ D.O.B.: _____

Name: _____ D.O.B.: _____

Name: _____ D.O.B.: _____

## Caregivers

Name: _____ Relationship to Parent: _____

Address: _____

Cell Phone: _____ Home Phone: _____

Name: _____ Relationship to Parent: _____

Address: _____

Cell Phone: _____ Home Phone: _____

## Specialist Information

Name:_____ Specialty: _____

Address: _____

Phone:_____ Fax: _____

Name:_____ Specialty: _____

Address: _____

Phone:_____ Fax: _____

Name:_____ Specialty: _____

Address: _____

Name:_____ Specialty: _____

## Agncies (E.I.,PT, OT, etc)

Name:_____ Specialty: _____

Address: _____

Phone:_____ Fax: _____

Name:_____ Specialty: _____

Address: _____

Phone:_____ Fax: _____

Name:_____ Specialty: _____

Address: _____

Name:_____ Specialty: _____

*For Additional information regarding caregivers, specialists or agencies please use a separate sheet of paper.

Signature: _____ Print Name: _____

# PERSONAL HISTORY

Patient Name: _____

Address: _____

City: _____

State/Zip: _____

Home Phone: _____

Date of Birth: _____ Sex: _____

Type of Delivery: _____
Term: _____
Premature at _____
Pregnancy Number _____
Birth Weight _____ Length _____
Discharge Weight _____
Apgar Score _____
Circumcision _____
Blood Type _____

Do you have any allergies? _____

Allergic to: _____ Reaction: _____

Allergic to: _____ Reaction: _____

Allergic to: _____ Reaction: _____

## PREVIOUS HOSPITALIZATIONS

| Operation or Illness | Year | Hospital/Doctor |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

FAMILY HISTORY: Please check if a family member has had any of these conditions

| | FATHER | MOTHER | SIBLINGS | Maternal Grandparents | Paternal Grandparents |
|---|---|---|---|---|---|
| DIABETES | | | | | |
| HIGH BLOOD PRESSURE | | | | | |
| HEART DISEASE | | | | | |
| STROKE | | | | | |
| CANCER | | | | | |
| GOUT | | | | | |
| ARTHRITIS | | | | | |
| ASTHMA | | | | | |
| KIDNEY DISEASE | | | | | |
| COLITIS | | | | | |
| ULCERS | | | | | |
| OTHER | | | | | |
| OTHER | | | | | |
| OTHER | | | | | |
| | | | | | |
| STATE OF HEALTH IF LIVING | | | | | |
| CAUSE OF DEATH | | | | | |

DATE _____ SIGNATURE OF PARENT/GUARDIAN _____

Community Care Physicians, P.C.

# RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a copy of Community Care Physicians, P.C.'s
Print Patient Name

Notice of Privacy Practices.

_____ _____ _____
Signature of Patient or Guardian | Date of Birth | Date

_____ _____
Witness | Date